First Lieutenant Andrew K. Kinard, USMC (Ret.)

Good afternoon, Chairman Nelson, Senator Graham, and members of the committee. I am pleased to appear before you today to discuss my experiences as a warrior in transition. I hope that by sharing with you some of the challenges that I have faced and the successful experiences that I've had, this committee will gain a better understanding of the issues that are common to all recovering service members.

Although I have faced many challenges since I was wounded in Iraq two and a half years ago, let me first say that I wouldn't be here today were it not for the dedication and professionalism of the medical personnel who treated me from the battlefield through surgical centers in Al Asad, Balad, Landstuhl, Bethesda, and Walter Reed. Every breath that I take is a testimony to their service.

I was injured in the Al Anbar Province, Iraq on October 29, 2006. My subsequent medical evacuation and recovery consisted of over sixty surgeries and countless hours of occupational and physical therapy. I was an inpatient at Walter Reed when the Washington Post stories broke and remained there through all of the changes that followed. Some of the changes to the transition system have been very effective and others remain ineffective due to lack of oversight or interagency coordination.

As you have heard from the other witnesses, recovering service members are facing a myriad number of issues at each phase of transition – recovery, rehabilitation, and reintegration. These three phases were formalized by the Department of Defense (DoD) in the Directive-Type Memorandum of January 19, 2009 which establishes policy for the Recovery Coordination Program. One caveat is that the three phases cannot be viewed exclusively as a linear progression; it is not uncommon for reintegration to begin prior to the completion of rehabilitation or for a recovering service member to require services typically associated with the recovery or rehabilitation phases after reintegration is considered complete. For example, this is the case for many service members who have a Traumatic Brain Injury (TBI). Oftentimes they will have returned to their home communities but require ongoing cognitive therapy. I have tried to capture thematic issues faced by recovering service members at the second two phases of transition: rehabilitation and reintegration.

REHABILITATION

The need for competent care management at all phases of transition cannot be overstated, but it is especially critical during the rehabilitation phase as the recovering service member (RSM) navigates the various outpatient services available. Two programs are now available to assist RSMs in coordinating their care: the Recovery Care Coordination Program and the Federal Recovery Coordinator Program. While each of these two programs essentially provide the same service – with very seriously injured service members managed by a FRC and less severely service members managed by a RCC – the RCC program is managed by the Department of Defense and the FRC program is managed by the VA. It is essential that Congress not view these two programs as completely unrelated, but rather Congress should ensure interagency coordination as DoD and VA implement these relatively new programs.

Prior to the FRC and RCC programs becoming available, the onus was on the recovering service member to keep up with all of the different case managers and their individual responsibilities. When I was at Walter Reed Army Medical Center, I had a medical case manager, a non-medical case manager, a social worker, a medical board case manager, a Physical Evaluation Board Liaison Officer, a Navy-Marine Corps Liaison Officer, a Wounded Warrior Regiment case manager, and a Marine Corps patient administration team. This list of medical support personnel is roughly the same for all recovering service members in its composition and in the confusion it creates among wounded warriors. What became especially problematic before the advent of recovery coordinators was the transfer of a RSM to a different medical facility. At each transfer, RSMs commonly started fresh with case managers who had no previous knowledge of medical history for that patient.

The long list of case managers and other support staff that I previously mentioned all fall within the Department of Defense health care system. As service members transition from active to veteran status, most, if not all, of those case managers will be exchanged for new ones in the VA system. Rather than veterans navigate a new health system with no institutional memory of their medical history, a FRC or RCC can ensure a continuity of medical care.

Additionally, the net result of the number of support staff is that there is a broad diffusion of responsibility among case workers, and the recovering service member loses confidence in the government’s ability to maintain accountability of his care. Each case worker has a specific role in that service member’s recovery, and the burden of responsibility falls on the service member to keep track of which case manager provides each service. The assignment of a FRC or RCC provides the recovering service member with a single point of contact for decisions regarding his or her care. The effectiveness of these two programs, however, should not be measured exclusively by the mere presence of a policy statement outlining the program, but rather by continuous

assessments by stakeholders in the process and by recovering service members themselves.

REINTEGRATION

Disability Evaluation System (DES) Pilot Program

In an effort to simplify and streamline the process by which service members are medically evaluated, retired, and enrolled into the VA, the National Defense Authorization Act of Fiscal Year 2008 (NDAA 08) authorized the Secretary of Defense to develop a Disability Evaluation System pilot program. For those who are evaluated through the pilot, the advantages are that there is only one medical evaluation instead of two and that the veteran is immediately enrolled in the VA upon retirement. Those who are not a part of the pilot program must be medically evaluated by their service – with each service having different medical standards – then retire. Upon retirement, the veteran must then be medically evaluated by the VA and oftentimes wait many months before receiving disability compensation.

Despite the efficiencies gained by a single medical evaluation using a common standard, the process is often delayed because the disability claim jumps back and forth between the DoD and VA. Health records may be shared electronically, but disability claims are still printed out and physically sent through each office responsible for the paperwork.

Additionally, there has been no change in streamlining the case managers responsible for each claim. Each service member must keep track of up to five different case managers who each have some part in the claim process. DoD and VA have both retained a case manager for each segment of the pre-pilot process; the pilot should make an effort to reduce the number of case managers to a single case manager responsible for the entire claim process.

Employment

Many have recognized the need for purposeful activity for those assigned to the various wounded programs to promote recovery and prevent disciplinary problems. Fortunately, many local companies and organizations would like to hire wounded/ill/injured service members for internships while they are healing. These internships can provide a sense of purpose and provide work experience that can be helpful if and when the service member leaves the military. The Department of Defense operates a program called Operation Warfighter which places injured service members within the National Capitol

Region into internships at locally based federal agencies. This is a successful program but is very limited.

Allowing this program to expand across the country as well as allowing individuals to intern or have temporary assignment at a local, state, or federal agency or even a private company would provide a significant benefit to those assigned to one of the military services' wounded warrior units. From my personal experience, I didn't start feeling like my "old self" until I started an internship at the Pentagon working 20-25 hours a week in the time between physical therapy appointments.

SUMMARY

As the next panels of witnesses come up to testify, you know that they are well intentioned and have our best interests at heart. I respectfully request that you keep in mind two questions as you listen to their testimony:

1. How is effectiveness measured in each of the different programs?
2. How do you ensure that programs within each of the military departments and among different federal agencies are compatible with each other?

The senior leadership in the Department of Defense and the Veterans Administration have done a remarkable job in breaking down institutional barriers in the last two years to provide the best access to services and address difficulties with case management. Unfortunately, this level of cooperation has not yet been institutionalized at the end-user level – that of the recovering service member – and many issues remain at that level with respect to access to services and case management. Effective oversight of interagency coordination is essential as we move forward so that the men and women who have sacrificed so much are best equipped to recover, rehabilitate, and reintegrate as productive members of our society.

Thank you, Senator Nelson and Senator Graham for the invitation to appear before you today. I appreciate the opportunity to be a part of our American process...to come before you and present my perspective to an elected body that has the opportunity to make a difference for so many. I look forward to answering any questions you may have.